

These forms are for new patients only. Completing this form does not reserve an appointment or save your spot in line. After completing the forms, please print and bring with you to your center visit.



**PATIENT INFORMATION**

Last Name		First Name	Middle Initial	Suffix	DOB MM/DD/YYYY
<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		( ) - -	( ) - -	-	( ) - -
		Social Security Number	Home Phone		Mobile Phone
Address			Apartment Number		
City	State	Zip	Country		
Email @					
<b>Can this email be used for patient portal?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				Preferred Language	
Primary Care Physician (PCP)					
<b>Race</b>					
<input type="checkbox"/> American Indian or Alaska Native		<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American		
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> White			
<b>Ethnicity</b>					
<input type="checkbox"/> Hispanic or Latino			<input type="checkbox"/> Non-Hispanic or Non-Latino		
				( ) -	
<b>Pharmacy Name</b>				<b>Pharmacy Phone</b>	

**REASON FOR VISIT**

**EMERGENCY CONTACT**

Last Name	First Name	Middle Initial	Suffix	Relationship
( ) - -	( ) - -			
Home Phone	Mobile Phone			

**RESPONSIBLE PARTY/GUARANTOR**

<input type="checkbox"/> Same as Patient <input type="checkbox"/> Other (Fill out below information)					
Last Name		First Name	Middle Initial	Suffix	DOB MM/DD/YYYY
<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		( ) - -	( ) - -	-	( ) - -
		Social Security Number	Home Phone		Mobile Phone
Address			Apartment Number		
City	State	Zip	Country		
Email @					
Relationship					

**INSURANCE INFORMATION**

**Primary Insurance**

Insurance Company			Insurance Plan		
Address			Suite Number		
City ( ) -	State	Zip ( ) -			
Phone	Extension	Fax			
Insurance Number/Policy Number/Subscriber ID / /			Group Number		
Effective Date MM/DD/YYYY		Insured Relationship to Patient			
Insured Last Name	First Name	Middle Initial	Suffix	DOB MM/DD/YYYY ( ) -	
<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		Home Phone		Mobile Phone	
Employer					

**Secondary Insurance**

Insurance Company			Insurance Plan		
Address			Suite Number		
City ( ) -	State	Zip ( ) -			
Phone	Extension	Fax			
Insurance Number/Policy Number/Subscriber ID / /			Group Number		
Effective Date MM/DD/YYYY		Insured Relationship to Patient			
Insured Last Name	First Name	Middle Initial	Suffix	DOB MM/DD/YYYY ( ) -	
<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		Home Phone		Mobile Phone	
Employer					

# Patient Financial Responsibility and Consent for Treatment



## PATIENT INFORMATION

\_\_\_\_\_  
Last Name                      First Name                      Middle Initial      Suffix                      DOB: MM/DD/YYYY

I hereby give my consent and authorize Baptist Health Urgent Care Providers to perform reasonable and necessary medical examinations, including testing. I consent to permit the Provider to treat any medical condition provided that the health care Provider has explained my condition to me, the treatment procedures and alternative methods of treating my condition. I understand this Consent Form is an effort to obtain my permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

I authorize the Provider to perform any additional or different treatment, which is thought necessary should, during treatment, a condition be discovered which was not known previously. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s) being performed or services provided.

## PAYMENT, TREATMENT AND DATA AGREEMENT

- I understand I am responsible for any amounts not covered by my insurer, including charges and deductibles. If my insurance carrier denies any part of my claim, I am responsible for the entire remaining balance.
- I authorize a photocopy of this statement to serve as the original and the use of this signature on all insurance submissions.
- I am personally responsible for providing accurate and current insurance information.
- I authorize release of all information necessary to secure payment of benefits.
- I understand that any services not provided directly by Baptist Health Urgent Care (Lab results, diagnostic services) are a separate charge and those charges will be billed separately by the provider of such services.
- I authorize examination and treatment for this and all following associated medical visits.
- I understand this Consent will remain fully effective until it is revoked in writing. I have the right at any time to discontinue services.

I certify that the above information is true and correct. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its content.

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Date MM/DD/YYYY

**HIPAA AUTHORIZATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**CHOOSE ONE:**

I DO NOT authorize Baptist Health Urgent Care to release my medical and billing information to anyone other than myself.

OR

I authorize Baptist Health Urgent Care to release my medical and billing information to the individuals listed below:

<u>RELATIONSHIP</u>	<u>NAME OF DESIGNATED PERSON</u>	<u>PHONE</u>
SPOUSE <input type="checkbox"/> YES <input type="checkbox"/> NO	_____ Please Print	_____
CHILDREN <input type="checkbox"/> YES <input type="checkbox"/> NO	_____ Please Print	_____
IN-LAWS <input type="checkbox"/> YES <input type="checkbox"/> NO	_____ Please Print	_____
CAREGIVERS <input type="checkbox"/> YES <input type="checkbox"/> NO	_____ Please Print	_____
PARENTS <input type="checkbox"/> YES <input type="checkbox"/> NO	_____ Please Print	_____
OTHERS:	_____ Please Print	_____

**I authorize Baptist Health Urgent Care to leave information on my voicemail:**

HOME:  YES  NO

CELL:  YES  NO

WORK:  YES  NO

**I authorize Baptist Health Urgent Care to leave notice of breach on my e-mail:**

BREACH NOTIFICATION ONLY:    YES    NO

The HIPAA privacy rule permits health care providers to communicate with patients regarding their health care, including protected health information (PHI) and billing information. This includes communicating with the patient through mail, phone, encrypted e-mail, fax or some other manner.

I understand that Baptist Health Urgent Care is permitted by the HIPAA privacy rule to leave information regarding my appointment, including, the date and time, on any phone number(s) provided. Baptist Health Urgent Care may request a return phone call to our office by leaving a message or when speaking to any individual that answers the phone. If I only want confidential communication between myself and Baptist Health Urgent Care I must provide written notice to these entities on a form provided upon my request.

I understand that it is my responsibility to keep Baptist Health Urgent Care informed of any changes to this information and that I may revoke this authorization at any time by written notice to these entities on a form provided upon my request.

\_\_\_\_\_  
Signature of Patient or Personal Representative(Legal Guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
**MINOR Patient ONLY** - Print Name of Personal Representative (Legal Guardian)

\_\_\_\_\_  
Date



### Secure Pay Enrollment Form

By signing this form you give Urgent Team permission to charge your Credit/Debit/HSA card indicated below up to \$200 for any amount not paid by insurance. This authorization applies to each balance effective after the date of this authorization. Prior to charging your account, you will receive a statement notifying you of the amount due. Following the receipt of the statement, you will have 2 weeks from the statement date to contact Urgent Team if you would like to make alternative arrangements for payment. *Services to Include: Office visit and any related services including, but not limited to, Labs, x-rays, injections, any additional ancillaries, etc.*

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Please complete the information below:

I \_\_\_\_\_ authorize \_\_\_\_\_ (Center Name) to keep my signature securely on file and to charge my Credit/Debit/HSA card indicated below up to \$200 for any amount not paid by insurance.

Account Type:    Visa    MasterCard    AMEX    Discover	<u>OFFICE USE ONLY</u>
Cardholder Name: _____	Patient ID: _____
Credit Card # (Last 4): _____	
Cardholder Address: _____ (If different than patient)	

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

I authorize the above named business to charge the Credit/Debit/HSA card indicated in this authorization form according to the terms outlined above. I certify that I am an authorized user of this credit card. This authorization expires one year after the above date.

**Baptist Health Urgent Care**  
**Notice of Privacy Practices**  
**Acknowledgement**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will only be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly
- Obtain payment from third-party payers or responsible parties
- Conduct the healthcare operations of health care education, quality assessments and patient satisfaction surveys

A copy of the Baptist Health Urgent Care *Notice of Privacy Practices* was made available to me. It contains a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact Baptist Health Urgent Care at any time to obtain a current copy of the *Notice of Privacy Practices*.

\_\_\_\_\_  
**Signature of Patient or Personal representative**

\_\_\_\_\_  
**Date**

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**URGENT TEAM USE ONLY**

I attempted to obtain the patient’s signature in acknowledgement of the *Notice of Privacy Practices* Acknowledgement but was unable to do so as documented below:

Date:	Initials:	Reason:
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New Patients – we need your feedback!

## How Did You Hear About Us?

*Please check the one box that best describes how you heard about us.*

### ONLINE

- Facebook
- Promotional/Educational Email
- Search Engine (Google, Bing, etc.)
- Website Ad

### COMMUNITY

- Drove by/Building signs
- Event/Sponsorship
- Friends/Family Referral
- Physician/Pharmacy Referral

### PRINT/MEDIA

- Billboard
- Brochures/Flyer
- Mail/Postcard
- Newspaper/Magazine
- Radio
- OTHER** (Describe) \_\_\_\_\_

Thank you, we will use this information to better understand the community and how people find us. We are here to serve you and your family.